SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Filing at a Glance

Company: West Coast Life Insurance Company

Product Name: LORI-WCL100	SERFF Tr Num: PRTA-125795980	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40902
Sub-TOI: L08.000 Life - Other	Co Tr Num: LORI-WCL100	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Lori Nelson	Disposition Date: 11/24/2008
	Date Submitted: 11/19/2008	Disposition Status: Approved

Implementation Date Requested: 01/01/2009

Implementation Date:

State Filing Description:

General Information

Project Name: LORI-WCL100	Status of Filing in Domicile: Pending
Project Number: LORI-WCL100	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed concurrently
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/24/2008	
State Status Changed: 11/24/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

West Coast Life Insurance Company is a subsidiary of Protective Life Insurance Company. Protective Life Insurance Company represents West Coast Life Insurance Company in the submission of the above-referenced form and will negotiate with state insurance departments for their approval. A separate letter of authorization is not required due to subsidiary status.

The above referenced forms are being submitted for filing review and prior approval, as appropriate. These are new forms that will not replace any forms currently in use by the Company. This filing does not contain any unusual or controversial provisions. These forms will be used in the General Individual Life Insurance market. The proposed

implementation date for the filing is January 01, 2009 or upon approval by your Department. This application is being filed in our domiciliary state of Nebraska, concurrently.

Currently these forms will be used with the following previously approved products: WC-U12-AR 9-08 (Approved August 25, 2008), WC-U15-AR 11-06 (Approved October 25, 2006), 991238600 – Approved Sept 21, 1999 and 991238700 – Approved March 23, 1999, 0712102AR(Rev.08/07) (Approved October 25, 2007, SERFF Tracking Number PRTA-125312728, State Number 37061) and 0511317AR (Approved August 31, 2005, SERFF Tracking Number SERT-6F3TAT021).

These forms are submitted in final print format. However, due to rapidly changing technology, the Company reserves the right to make minor non-material format changes including, but not limited to: paper stock, type face (but not font size) and page layout that become unavoidably necessary as a result of computer hardware and/or software upgrades and print technology changes. We certify that any necessary format changes will not affect the specific content of the approved forms.

Required filing fees have been submitted via EFT.

If you need further information, I can be contacted via SERFF Notes, email at Lori.Nelson@protective.com or toll-free at 1-800-866-3555 ext. 4809.

Company and Contact

Filing Contact Information

Lori Nelson, Policy Contract Filing Contractor
2801 Hwy 280 South
Birmingham, AL 35202-0648

Lori.Nelson@protective.com
(800) 866-3555 [Phone]
(205) 268-3401[FAX]

Filing Company Information

West Coast Life Insurance Company
2801 Highway 280
Birmingham, AL 35223
(800) 866-3555 ext. [Phone]

CoCode: 70335
Group Code: 458
Group Name:
FEIN Number: 94-0971150

State of Domicile: Nebraska
Company Type: Life Insurance
State ID Number:

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	$50 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
West Coast Life Insurance Company	$50.00	11/19/2008	24035486

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	11/24/2008	11/24/2008

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Disposition

Disposition Date: 11/24/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Form	Individual Life Application		Yes
Form	Agent's Report Form		Yes
Form	Application for Reinstatement or Policy Change		Yes
Form	HIPAA Notice		Yes

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Form Schedule

Lead Form Number: WCL-100 (9/08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WCL-100 (9/08)	Application/ Enrollment Form	Individual Life Application	Initial		53	WCL-100_9.08.pdf
	WCL-106 (9/08)	Application/ Enrollment Form	Agent's Report Form	Initial		54	WCL-106_9.08.pdf
	WCL-343 (9/08)	Application/ Enrollment Form	Application for Reinstatement or Policy Change	Initial		52	WCL-343 (9.08).pdf
	WCL-359 (9/08)	Application/ Enrollment Form	HIPAA Notice	Initial		54	WCL-359_9.08.pdf

West Coast Life
Insurance Company
A PROTECTIVE COMPANY

P.O. Box 193892, San Francisco, CA 94119-3892

Part I

SECTION I : INSUREDS

[State of Domicile - Nebraska]

LIFE INSURANCE APPLICATION

Name of Persons Applying for Coverage (Print in Full)	Relationship to Prop. Ins.	Sex	Date of Birth	Social Security Number	Birth State	Driver's License Number
Proposed Insured	Self					
Spouse						
Child						
Child						

Residence: _____

Street Apt. No.

_____

City State Zip Code Telephone Number Number of Years

Occupation	# of Years	(Required) Annual Income	(Required) Net Worth	Employer Name and Address	Telephone Number
Proposed Insured's Occupation					
Spouse's Occupation					

SECTION II : PLAN OF INSURANCE

Face Amount $ _____ $ _____ $ _____

Insured Spouse Children

Plan of Insurance *(Name of Product)* _____

If Universal Life: ☐ OPTION I - Level Face Amount ☐ OPTION II - Face Amount Plus Cash Value

If Term, Indicate Years: ☐ 10 Yrs ☐ 15 Yrs ☐ 20 Yrs ☐ 25 Yrs ☐ 30 Yrs

If Income Replacement Term: Complete the Supplemental Application Form #WC-U-413

Not Available on all plans: 1035 Loan Transfer ☐ Yes ☐ No Section 1035 ☐ Yes ☐ No

☐ CVAT (unless checked, the Guideline Premium Test will apply.)

Benefits: ☐ Automatic Premium Loan ☐ Waiver of Premium ☐ Accidental Death, Amount: $ _____

☐ Child Rider, # of Units: _____ ☐ Other, Description and Amount: _____

Premium Payment: ☐ Annual $ _____ ☐ Check-O-Matic $ _____ ☐ Other _____

☐ Additional 1st Year Payment $ _____ ☐ Cash with Application $ _____

Send Premium Notices To: ☐ Residence ☐ Other, Complete Line Below:

_____

Name Address City State Zip

SECTION III : BENEFICIARY

Primary: Full Name _____ _____

Relationship

_____

Address City State Zip

Secondary: Full Name _____ _____

Relationship

_____

Address City State Zip

SECTION IV : NON-MEDICAL HISTORY *(Must be answered for all Proposed Insureds)* Part I

HAS PROPOSED INSURED:	Prop. Ins. Yes	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children No
1. Used tobacco or nicotine of any kind over the last 5 years? Type: Frequency: Date last used:	☐	☐	☐	☐	☐	☐
2. Consulted a physician or had treatment for the use or possession of: A. Alcohol?	☐	☐	☐	☐	☐	☐
B. Narcotics, stimulants, sedatives, hallucinogenic drugs?	☐	☐	☐	☐	☐	☐
3. In the past 5 years, been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs, or (iii) had their driver's license suspended or revoked?	☐	☐	☐	☐	☐	☐
4. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them?	☐	☐	☐	☐	☐	☐
5. Flown as a pilot, student pilot, or crew member, or intend to fly as such?	☐	☐	☐	☐	☐	☐
6. Been a member of , or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please list: branch of service, rank, duties, mobilization category and current duty stationin Section VI below.)*	☐	☐	☐	☐	☐	☐
7. Engaged in auto, motorcycle or boat racing, parachuting, skin or SCUBA diving, skydiving, hang gliding or other hazardous avocation or hobby?	☐	☐	☐	☐	☐	☐
8. Had a request for life or health insurance declined, postponed, rated, canceled, or restricted in any way?	☐	☐	☐	☐	☐	☐
9. Any application for any other life or health insurance on your life now pending or contemplated in this or any other company?	☐	☐	☐	☐	☐	☐
10. Is there an intention that any party, other than the owner, will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?	☐	☐	☐	☐	☐	☐
11. Is Proposed Insured:						
a). A citizen of any other country besides U.S.? If so, what country? _____	☐	☐	☐	☐	☐	☐
b). Have you lived outside of North America at any time during the last 3 years?	☐	☐	☐	☐	☐	☐
c). Intending to travel outside the United States or Canada within the next 12 months?	☐	☐	☐	☐	☐	☐
To where: When:						
Why: For how long:						

SECTION V : MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR OR TOLD YOU HAD:	Prop. Ins. Yes	Prop. Ins. No	Spouse Yes	Spouse No	Children Yes	Children No
12. A. Cancer, diabetes, epilepsy, heart disorder, high blood pressure, stroke, mental or nervous disorders, tumors, ulcers, or any disorder of bladder, kidney, liver or lungs?	☐	☐	☐	☐	☐	☐
B. AIDS (acquired immune deficiency syndrome) or ARC (AIDS-related complex)?	☐	☐	☐	☐	☐	☐
C. Arthritis, gout, or other disorders of muscles, joints, spine, stomach, intestines, or chest pain or asthma?	☐	☐	☐	☐	☐	☐
HAVE YOU:						
13. Within the last 12 months, had any kind of medication prescribed?	☐	☐	☐	☐	☐	☐
14. Been advised to have, or contemplated having a surgical operation?	☐	☐	☐	☐	☐	☐
15. Within the last 5 years, suffered from any disease, or received medical or surgical treatment for any condition not listed in question 12?	☐	☐	☐	☐	☐	☐
16. List current height and weight for all persons proposed for coverage. Height			_____		_____	
(If more than one child proposed for insurance, list in Section VI below.) Weight			_____		_____	

SECTION VI : DETAILS TO ANY "YES" ANSWERS TO QUESTIONS #1 THROUGH #15 ABOVE

(Must be answered, if applicable)

Name of Proposed Insured	Question Number	Date	Details or Reason	Name, Address, and Phone Number of Attending Doctor or Hospital

SECTION VII : EXISTING COVERAGE AND PENDING INSURANCE

Part I

(Must be answered completely on all cases.)

17. Regarding all persons proposed for insurance, list all life insurance in force on each proposed insured's life.
Please be sure to include insurance whether owned by the insured or not. If "none" please state it below.

Name of Insured	Company	Contract Number	Type of Coverage	Life Amount	Business or Personal	Year Issued

SECTION VIII : REPLACEMENT *(Must be answered completely on all cases.)*

18. Is the policy applied for to replace an existing insurance or annuity policy(ies) in this or any other company? ☐ Yes ☐ No
(If 'yes', give details in Section XI below and complete any State required replacement forms and comparison statements.)

SECTION IX : OWNERSHIP OF POLICY

Name of Owner (if other than Proposed Insured) Social Security No. or Taxpayer I.D. No.

Address City State Zip Code

SECTION X : BUSINESS INSURANCE

a. What is the purpose of the insurance (Key Person, Buy & Sell, Split Dollar, etc.)?

b. What percent of business does Proposed Insured own or control? %

c. What is approximate net annual income of business? $

d. What is approximate net worth of business? $

e. What year was the business established?

f. Business insurance on other Owners, Officers, Partners, or Key Persons

Name and Title	% of Business Owned	Insurance Company	Amount Now Carried or Applied For
	%		$
	%		$
	%		$

SECTION XI : REMARKS AND SPECIAL REQUESTS

Home Office Endorsements:

DECLARATIONS

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

1. All such statements and answers shall be the basis for and a part of any policy issued on this application.
2. No agent or medical examiner can accept risks or make or change contracts or waive West Coast Life's rights or requirements.
3. No insurance shall take effect unless the Proposed Insured(s) is (are) alive and in the same condition of health as described in this application when the policy is delivered to the Owner and the full first premium is paid. However, if the full first premium is paid as set forth in the attached Conditional Coverage Receipt and this Receipt is delivered to the Owner, the terms of this Receipt shall apply.
4. Acceptance of a policy by the Owner shall constitute ratification of any changes made by West Coast Life under "Home Office Endorsements." In those states where it is required, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties according to state law.

Signed At _____ Date _____
(City and State)

(X) _____ (X) _____
Signature of Proposed Insured Signature of Spouse, If Proposed for Insurance

(X) _____ (X) _____
Signature of Owner, If Other than Proposed Insured Signature of Agent

AGENT'S REPORT

I CERTIFY THAT: (1) THE ANSWERS GIVEN IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF; (2) I KNOW OF NOTHING AFFECTING THE RISK WHICH IS NOT SET FORTH IN MY AGENT'S CONTRACT OR THIS LIFE INSURANCE APPLICATION; AND (3) I CAREFULLY EXPLAINED EACH QUESTION BEFORE RECORDING EACH ANSWER AND BEFORE THE APPLICATION WAS SIGNED.

1. Do you understand that no final underwriting offer is valid unless a policy has been issued and delivered? ☐ Yes ☐ No
2. How long have you known insured? _____ Years _____ Months
3. Is insured a relative or does the insured have a business relationship with you? ☐ Yes ☐ No
4. Does proposed insured appear healthy and free from visible or known impairments or disability? ☐ Yes ☐ No
5. Do you have any reason to believe that the life insurance policy applied for will replace any life insurance or annuity from West Coast Life or another company? ☐ Yes ☐ No
   (If YES, Provide policy number(s) and company(ies) below, and complete any comparison statements required by law.)
   _____
6. Have you advised the proposed policyowner or do you know of any advice that has been given to the proposed policyowner to transfer the ownership of the policy being applied for to a life settlement company or other entity associated with stranger owned or investment owned life insurance (commonly called SOLI or IOLI) or are you otherwise aware that the policyowner may be contemplating such a transfer? ☐ Yes ☐ No
7. Is Premium Financing involved in this case? *(If YES, please submit a cover letter describing the parameters.)* ☐ Yes ☐ No
8. Family History

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?		Cancer History?		Type
Father			☐ No	☐ Yes, age of onset _____	☐ No	☐ Yes, age of onset _____ If Yes, date of onset _____	
Mother			☐ No	☐ Yes, age of onset _____	☐ No	☐ Yes, age of onset _____ If Yes, date of onset _____	
Siblings			☐ No	☐ Yes, age of onset _____	☐ No	☐ Yes, age of onset _____ If Yes, date of onset _____	

9. INDICATE CLASSIFICATION BASIS FOR THIS SALE: ☐ Super Preferred ☐ Preferred ☐ Standard
   ☐ Rated Table A, B, C, D, E, F, H (circle one) ☐ Other _____ ☐ Non-Tobacco ☐ Tobacco

Place any special remarks here:

I have verified the identity of the Owner by picture I.D. (Does not apply to direct marketing situations.) Identification type: _____

Please include Driver's License Number if Owner is other than the Proposed Insured. _____
In Georgia, please include a copy of the Driver's License with application.

BGA Name: _____

BGA Contract Number: _____

For Underwriting and New Business Contact Purposes:

BGA Fax Number: _____

BGA E-Mail Address: _____

_____ Agent's Signature	_____ Agent's Commission Code No.	_____ Business Phone
_____ Agent's Printed Name	_____ Agent's E-Mail Address	_____ Date Place

_____ Agent's Signature	_____ Agent's Commission Code No.	_____ Business Phone
_____ Agent's Printed Name	_____ Agent's E-Mail Address	_____ Date Place

West Coast Life Insurance Company
A PROTECTIVE COMPANY
P.O. Box 2606 • BIRMINGHAM, AL 35202

Application for Reinstatement or Policy Change

Owner's Address: _____

Phone: _____ E-Mail: _____

1. Reinstate Policy No. _____ on the lives of _____

   The insured must complete the Declaration of Insurability section below, and both Owner and Insured must sign the application.

2. Amend, Endorse or Reissue Policy No. _____ on the life of _____ as follows

   _____

   _____

   (Examples: reduce benefit amount; cancel ADB, etc.)

DO NOT USE THIS APPLICATION TO ADD A SPOUSE RIDER OR CHILDREN'S TERM RIDER...
USE A STANDARD APPLICATION.

Declaration of Insurance	Insured YES	Insured NO	Spouse YES	Spouse NO
1. To the best of your knowledge and belief, have you or any dependents who are insured:				
a) Used any form of tobacco since the original policy issue date? (including nicotine substitutes or nicotine products) Quantity used _____, date last used _____.	☐	☐		
b) Has Spouse (if coverage applied for) used any form of tobacco since the original policy issue date? (including nicotine substitutes or nicotine products) Quantity used _____, date last used _____.			☐	☐
c) Been charged with driving while impaired (alcohol, drugs, other) violation, had a driver's license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	☐	☐	☐	☐
d) Applied for issuance or reinstatement of any policy and been rejected, postponed or rated during the last 5 years?	☐	☐	☐	☐
e) Have an application pending in another company?	☐	☐	☐	☐
f) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐	☐	☐
g) Engaged in parachuting, scuba diving, mountain climbing, racing or other hazardous sport or intend to do so?	☐	☐	☐	☐
h) Used intravenous drugs, cocaine, barbiturates, hallucinogens, marijuana, hashish, sought advice or treatment for alcohol or drug use or used illegal drugs or prescription drugs not prescribed by a doctor within the last 5 years?	☐	☐	☐	☐
2. Does any Proposed Insured have any intention to travel or reside outside of the US, Puerto Rico, or Canada? (if yes, complete a foreign Travel questionnaire)	☐	☐	☐	☐
3. Has any of Insured's natural parents and/or siblings, either living or deceased, been diagnosed with or had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease since the original policy issue date? (If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death in Remarks.)	☐	☐	☐	☐
4. Does any Insured receive Medicare or Medicaid?	☐	☐	☐	☐
5. Are all Insureds US Citizens?	☐	☐	☐	☐
6. Has any Insured ever made claim or received indemnity for injury or illness?	☐	☐	☐	☐

7. a) Insured's current Height _____ Weight _____

   Name, Address, and Phone No. of usual medical advisor (and Doctor last consulted, if different)

   _____

   Date and reason of last visit? _____

   What diagnosis and treatment was given or medication prescribed? _____

   If None, then write None here: _____

   b) Spouse's (if insured) current Height _____ Weight _____

   Name, Address, and Phone No. of usual medical advisor (and Doctor last consulted, if different)

   _____

   Date and reason of last visit? _____

   What diagnosis and treatment was given or medication prescribed? _____

   If None, then write None here: _____

	Insured		Spouse	
	YES	NO	YES	NO
8. Has any Insured been told since the original policy issue date they had, or received treatment or advice for: a) abnormal blood pressure or elevated cholesterol?	☐	☐	☐	☐
b) chest pain, coronary heart disease, heart attack, heart murmur, abnormal ECG, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder of the heart, blood vessels or cerebrovascular system?	☐	☐	☐	☐
c) cancer, tumor, polyps, moles, basal or squamous cell carcinoma, melanoma, leukemia, lymphoma, or any other growth or malignancy?	☐	☐	☐	☐
d) diabetes, thyroid disorder, anemia, unusual bleeding, hepatitis, skin disorders, lupus, blood clots, or any other blood or glandular disorder, circulatory disorder, or acute or chronic Hepatitis B or C?	☐	☐	☐	☐
e) any disorder associated with the ears, hearing, speech, eyes, nose, throat, lungs or respiratory system, including but not limited to emphysema, pulmonary fibrosis, COPD, or other lung disorders?	☐	☐	☐	☐
f) any disorder of the stomach, intestines, rectum, liver, or pancreas, including but not limited to cirrhosis of the liver?	☐	☐	☐	☐
g) any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐	☐	☐
h) epilepsy, seizures, dizziness, paralysis, coma, multiple sclerosis, Motor Neuron disease (ALS), loss of speech, brain disorder, or any other disease or disorder of the nervous system?	☐	☐	☐	☐
i) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐	☐	☐
j) any disease or disorder of the kidney, bladder, prostate, or reproductive organs?	☐	☐	☐	☐
k) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?	☐	☐	☐	☐
l) breast disorders including lumps, cysts, other physical changes, abnormal mammogram findings or biopsy?	☐	☐	☐	☐
9. Other than as stated above, has any Insured within the past 5 years: a) consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	☐	☐	☐	☐
b) had any abnormal diagnostic tests (such as but not limited to lab work, PSA - Prostate Specific Antigen, PAP Smears, urinalysis)?	☐	☐	☐	☐
c) been aware of any symptoms for which a medical advisor has not yet been consulted?	☐	☐	☐	☐
d) been advised to have any diagnostic test, consultation, hospitalization or surgery that has not been completed?	☐	☐	☐	☐
10. Is there an intention that any party other than the owner will obtain any right, title or interest in any policy issued on the life of the proposed insured as a result of this application? If yes, please explain in the space provided below.	☐	☐	☐	☐

11. **LIST ALL INSURANCE IN FORCE ON EACH PROPOSED INSURED'S LIFE. INCLUDE INSURANCE WHETHER OWNED BY THE INSURED OR NOT. (IF NONE, PLEASE LEAVE BLANK.)**

Person	Policy #	Company Name	Issue Date	Amount	Purpose (Business/Personal)	Type (Life/ADB/CI)	REPLACEMENT YES	REPLACEMENT NO
							☐	☐
							☐	☐
							☐	☐

Please provide details to all questions answered (YES) to questions 1-10 above. Give question number, dates, and if applicable, provide the full name and address of all physicians or practitioners consulted, and all hospital(s) and clinic(s) in which treatment has been received.

Any person who knowingly with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties, according to state law.

Date Signed _____

Witness _____ Insured _____

Address _____ Owner _____

IMPORTANT

Please complete the attached authorizations. Please read and detach the description of information practices and retain for your records.

Your application for Policy Change has been approved by the Company. Your policy is amended. This shall be an Endorsement to your policy and shall be proof of such change.

Date _____ By _____
Authorized Officer

WEST COAST LIFE INSURANCE COMPANY • P. O. Box 193892 • San Francisco, CA 94119-3892

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. **(MIB)**; (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies **(CRA)**. All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING**. If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.
6. This authorization shall be valid for 12 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 193892 • San Francisco, CA 94119-3892.
   If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. ☐ I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
   ☐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*
   ☐ If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.
   I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment).**

THIS AUTHORIZATION <u>MUST</u> BE SIGNED <u>WITHOUT MODIFICATION</u> AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

_____	_____	**Date of Authorization:** _____
Proposed Insured 1 (Signature)	Date of Birth	When applicable, print name(s) of minor(s) below:
_____	_____	_____
Print Name	Social Security #	
_____	_____	_____
Proposed Insured 2 (Signature)	Date of Birth	
_____	_____	_____
Print Name	Social Security #	**Health Care Provider**
_____		_____
Parent or Legal Guardian (Signature)		Physician Name
		_____
		Physician Name

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PRTA-125795980*	*State:*	*Arkansas*
Filing Company:	*West Coast Life Insurance Company*	*State Tracking Number:*	*40902*
Company Tracking Number:	*LORI-WCL100*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*LORI-WCL100*		
Project Name/Number:	*LORI-WCL100/LORI-WCL100*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 08/28/2008

Comments:

Attachment:

AR Certification (WCL).pdf

Review Status:

Satisfied -Name: Application 08/28/2008

Comments:

Application is under Form Schedule Tab.

WEST COAST LIFE INSURANCE COMANY
BIRMINGHAM, ALABAMA

CERTIFICATION OF COMPLIANCE

FORM(S):	WCL-100 (9/08)	Individual Life Application
	WCL -359 (9/08)	HIPAA Notice
	WCL-343 (9/08)	Application for Reinstatement or Policy Change
	WCL-106 (9/08)	Agent's Report Form

This is to certify that the enclosed form(s) are in compliance with Rule and Regulation 19 of the State of Arkansas regarding the Unfair Sex Discrimination in the Sale of Insurance.

Keith Kirkley

Digitally signed by Keith Kirkley
DN: cn=Keith Kirkley, c=US, o=Protective Life Insurance Company, ou=Policy Contracting & Filing, email=keith.kirkley@protective.com
Date: 2008.09.09 12:09:52 -05'00'

(SIGNATURE)

September 12, 2008

(DATE)

Keith Kirkley, J.D., MBA

(PRINTED NAME)

Assistant Vice President

(TITLE)